Ambush, by Heather S. Englehart, acrylic on tent canvas, Iraq, 2004.
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Chapter 3

TROUBLING ISSUES IN MILITARY FORENSIC PSYCHIATRY

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INTRODUCTION

This chapter addresses issues that may be "troubling" for military psychiatrists when they conduct forensic evaluations in the military. These issues may be troubling, in part, because they involve conflicting moral values.[1,2] These conflicts may cause military psychiatrists anxiety. Anxiety caused by moral conflict is now commonly referred to as "moral distress."[3]

Three kinds of troublesome conflicts that may cause this kind of distress will be covered in three main sections. Each section will include one or more case examples based on actual conflicts that have occurred.

The first kind of conflict occurs when military psychiatrists interview soldiers who seem to be overly compliant. These soldiers may believe that they must still "follow orders." Even though the military forensic psychiatrist has appropriately "warned" soldiers that the psychiatrist is not trying to treat them, but is working in a forensic capacity only, these examinees may, in this forensic context, still act against their own interests. The case presented involves a military psychiatrist who interviewed a retired soldier to assess his claim that he had acquired emotional problems while in the military. This psychiatrist was concerned about whether to wear a military uniform or civilian clothes for this interview. This example is exceptional. It represents how moral conflicts can occur if soldiers are overly compliant. This section suggests that when military psychiatrists fear that soldiers may be excessively compliant during forensic assessments, they may then take exceptional initiatives to try to ensure that these soldiers do not inadvertently act against their best interests. These additional initiatives may be ethically necessary to help bring about a more just result.

The second kind of conflict occurs when military psychiatrists are conflicted within themselves, which may most likely happen when they are in a moral "bind." This bind may be between saying what they believe is true versus saying what they believe is in their own best interests. They may, for example, disagree with other more experienced military forensic psychiatrists, but believe that it is in their best interests to agree with them, either to protect their military career or their personal, emotional interests in retaining the professional respect of these other psychiatrists.

The third kind of conflict occurs when special circumstances exist such that standard approaches psychiatrists would take in responding to forensic tasks would, they believe, lead to suboptimal results. In this situation, they would have to decide whether to engage in unusual practices. In the first case presented below, the soldier may have acted compulsively, but the likelihood that this act was "compulsive" as opposed to "voluntary" is speculative. In the second case, the soldier may have had a paradoxical reaction to a drug. These inferences—whether or not the soldier acted compulsively and had a paradoxical reaction—are subjective and less well grounded than many inferences psychiatrists make in forensic cases. Their conclusions, therefore, may be more controversial than most others. Consequently, in these instances, psychiatrists may be more personally vulnerable and fear that other psychiatrists will be more likely to judge their forensic skills as deficient. Since these conclusions are more open to disagreement, psychiatrists making these judgments may have greater personal concerns that other psychiatrists will disagree with their conclusions and possibly question their forensic skills. This situation may be especially troubling if they are in a role in which other psychiatrists are teaching them and must evaluate them as opposed to working with them regularly. In the first instance, they may jeopardize their careers; in the second, they risk losing their colleagues' respect.

This discussion will suggest that when psychiatrists feel this conflict, they should express these feelings. Others—namely their teachers and colleagues—should seek ways to reduce these psychiatrists' "bind" by reducing the sources of the feelings of vulnerability. These same approaches will also reduce potential harm to the soldiers they examine.

The third section will also examine situations in which military psychiatrists feel that morally they may achieve the best outcomes for patients if, again, they act outside the usual standards of forensic psychiatry practice. In these cases, their conflict does not involve their personal needs, but stems from wanting to do their best for these soldiers.

Both cases in the third section involve psychiatrists assessing soldiers for mental capacity to make what may become life-or-death decisions. The first case involves a soldier who recently acquired sudden traumatic quadriplegia and wants to be allowed to die because of this injury. The second case involves a soldier who wants to refuse a life-saving amputation. Both soldiers experienced a blast injury. If the psychiatrists judge these soldiers to have adequate capacity, it will make it more likely that they will be deemed legally competent to make the decisions facing them. They may then refuse life-saving interventions. In some of these cases military psychiatrists may believe that these soldiers are cognitively "intact," such that they would meet the usual criteria for having the capacity to make decisions, but that emotionally they are too impaired to make the best decisions for themselves.

The discussion will suggest again that military psychiatrists should be encouraged to express their concerns to their colleagues. It will suggest more generally that in all three of these kinds of conflicts, military psychiatrists should ask themselves if they are feeling moral distress. If they can identify this distress, they should share what they are feeling with others. This may help enable them and those with whom they work to produce more favorable outcomes for them, the military, and the soldiers and patients.

SOLDIERS SEEMING OVERLY COMPLIANT

Soldiers are generally expected to obey orders for good reasons.[4] For example, soldiers have more access to dangerous weaponry than civilians. Thus, there is a greater need for the military to define clearly what soldiers should do, and when—specifically—they should and should not use these weapons. Having commanders give orders tends to create a greater habit among some soldiers to more "automatically" comply. All soldiers are expected to comply with orders unless they consider them illegal or unethical. Some soldiers, however, will acquire a psychological tendency to comply with orders reflexively without thinking or without reflecting on them. They may then be more vulnerable to responding in ways they might not want to, if they gave this "automatic habit" greater thought.

This tendency may be ethically problematic in some forensic contexts. For example, when military psychiatrists serve in forensic roles, they may be serving the interests of the military or society as opposed to the soldiers. Forensic psychiatrists in all such settings, military or civilian, consequently "warn" those they examine that they will be serving other interests. Yet, this problem may be greater when those examined are soldiers because they are more used to obeying orders—"automatically" and quickly—from higher ranking officers. These soldiers may be more vulnerable, therefore, when examined by military forensic psychiatrists who have higher rank. Because of their prior military training and past experience, they may be more at risk of giving information against their best interests because they have been "overly compliant." They may respond in this way without even knowing that they are doing so, or before they become aware that they have done so.

Accordingly, when examinees are soldiers, warnings that psychiatrists give patients when conducting forensic exams may be less effective than forensic psychiatrists give in civilian settings. The customary warnings that forensic psychiatrists give in civilian settings may not suffice in the military setting. If soldiers are in general more inclined to respond "compliantly," it may be that in the military setting these warnings should increase.

Case Study 3-1*:* A military psychiatrist was tasked by the military with interviewing a recently retired soldier who was claiming monetary compensation for an emotional harm incurred in the military. The interview was to occur outside a military post.

The psychiatrist struggled over whether to wear his military uniform with his officer's rank or a suit. If he wore his uniform, it might evoke too much compliance, or it could have the opposite effect. Wearing his uniform could convey "constantly" to the retired soldier that the psychiatrist was in the military and working for "the other side."

Discussion: The importance of attending to the possibility of soldiers overly complying has been recognized in other settings. Those with authority have been required to take special measures to avoid undue, harmful effects. This concern is exemplified, for example, when soldiers participate in military research.[5] Strict limitations exist to ensure that soldiers do not feel coerced. Those authorities higher in soldiers' chains of command are precluded from describing research in which they are investigators and hope these soldiers will participate. The concern here is that soldiers may not feel sufficiently free to choose to not be in such research under these conditions. It is feared that the mere presence of these authorities may make these soldiers feel obligated to participate in the study. They may believe it is their duty to comply with the wishes of those in command.

This risk of an interviewee overly complying against his or her interests in a forensic psychiatric interview exists in many settings, such as those involving alleged criminal behavior and those evaluating claims for compensation (such as the case described previously). Thus, when working for the "other side," psychiatrists conducting such interviews should always consider the extent to which they should provide "warnings."

Forensic psychiatrists strive to assess those they examine as objectively as possible. Yet, for various reasons, the information that psychiatrists provide may differ and favor or disfavor their examinee's interest, depending on which "side" they are working with. The lawyers, on each side, represent their "side's" interest, and may choose to pursue only information favorable to that side. The notion that greatest justice is achieved by each side presenting its best case so that a judge or jury can decide what to believe is at the foundation of the US legal system. Forensic psychiatrists may speak impartially to some extent, but not completely. Thus, they always give a warning, "What you say may be used against you," when this is the case. The question is whether they should repeat this more often when they fear that examinees may have temporarily forgotten

it due to gaining—in this setting—undue and unwarranted trust. Without such warnings, examinees may, at least in theory, be more likely to act unwittingly against their best interests.

Furthermore, establishing trust and rapport is psychiatrists' "bread and butter." Accordingly, all psychiatrists tend to establish trust and rapport (even inadvertently), which may result in examinees unwittingly violating their own best interests. Therefore, ethically, if not legally, psychiatrists, as well as other physicians, should "warn" those they forensically examine whenever they suspect this.

Another kind of example arising for some military psychiatrists under previous military law involved homosexual soldiers. Even in clinical settings, some military psychiatrists believed that they had a duty under some circumstances to report homosexual behavior. Decades ago, military lawyers sometimes had different legal views on when, if ever, this was the case, and some said that there was such a duty. Others said no duty existed. In any case, if psychiatrists then believed they had such a duty, they also ethically had another duty: they had an ethical obligation to disclose to the soldiers that they would disclose their sexual orientation before the soldiers themselves might disclose it.

Under current circumstances, this ethical obligation to provide a warning may still exist in clinical settings when soldiers report that they have used illegal drugs. When military physicians take a drug history, soldiers may disclose information that could work against them. For this reason, when military physicians anticipate that soldiers could be harmed by what they say about their illegal drug use, ethically they should tell them in advance what they would do with this information.

The paradigmatic example of when this warning is required, again, is in military research. If soldiers give information that could harm them when they participate in research, then, this warning is required. In such cases, soldiers must be informed that they are not absolutely protected from harmful repercussions.

In the forensic setting, in some cases military psychiatrists should warn examinees more than once. This warning may have the paradoxical effect of increasing these examinees' trust. This could result, again, in soldiers revealing more than is in their best interests.

The implicit lesson here for military psychiatrists conducting forensic exams is that they should ask themselves what added warnings, if any, they should provide. They should ask what warnings they should give, even if these additional warnings go beyond what they would do if they were examining civilians. They should also ask analogous questions, such as what they should wear, as the military psychiatrist did in the above case.

MILITARY PSYCHIATRISTS FEELING CONFLICTED

Influence of Military Career Hopes

Psychosocial pressures affect all people and often without their awareness. For example, Solomon Asch's studies performed decades ago showed how far people's views can be altered without their awareness in response to peer pressure.[6] More recently, this same effect was seen in studies showing the extent to which physicians may be influenced by accepting even small gifts from pharmaceutical companies. This influence may occur without their knowledge. Even when physicians believe that other doctors accepting such gifts may be affected, they tend to believe—erroneously—that they would not be affected without their awareness.[7]

One context in which military psychiatrists may be particularly vulnerable to such an unknown, outside influence is when they have aspirations regarding their military careers.[8] The military is a somewhat small, closed system. Consequently, soldiers must compete for promotion and success in their military careers. Some will become generals and others will not.

One such context in which competition may affect military psychiatrists is when they are in training, such as during a forensic fellowship. After this fellowship, only some will be chosen for desirable positions. For some military psychiatrists, this situation will create pressure to make judgments that would be more compatible with the views of those who will be evaluating their performance, even if "in their hearts" they believe something else.

Case Study 3-2: A military psychiatrist was in a training program to learn how to conduct forensic evaluations. He evaluated residents at a civilian forensic center for criminal competency and insanity.

Other psychiatrists there, who were his teachers and evaluators, believed that a resident he was evaluating had only a personality disorder. However, the psychiatrist believed that the resident had a psychosis and had been psychotic and not criminally responsible due to his psychotic thinking at the time of his "crime." The psychiatrist believed he faced two options: (1) he could say what he believed, stick to it, and risk being judged as forensically "limited;" or (2) he could agree with his teachers' assessments and avoid this risk. If he avoided the risk, his military career advancement would be more likely.

Discussion: This psychiatrist maintained his opinion about the resident. Psychiatrists adhering to their own views may risk harming their military careers, but they also may set themselves apart from others in a positive way and enhance their career advancement possibilities. It may be that this is what actually happened in the above case. It is critical in all such cases for military psychiatrists to consider that their self-interests could affect them, consciously or unconsciously, in these contexts. Again, research offers another context in which this same kind of influence is a concern. Institutional review board (IRB) members voting on what research to conduct must determine whether they have a conflict of interest. If they do, they must recuse themselves from decision making and some discussions. If they own stock in a company that is sponsoring the research, both parties may benefit if the research is approved. These potential members must recuse themselves because a conflict of interest is apparent.

Military psychiatrists who do forensic work always should consider potential conflicts of interest, and they should consider whether they consciously recognize conflict. If their forensic work could affect their military careers, they should consider how this concern could affect them, even unconsciously.

Influence of Military Peers

In the military, as elsewhere, military psychiatrists want to retain their colleagues' respect and affection. It is tempting to imagine that military psychiatrists doing forensic work could be sufficiently invulnerable to their emotional needs and always remain impartial. However, this is unlikely to be true of many people, if not all.

Military psychiatrists doing forensic work may know each other well, particularly because this professional population is small.[9] The number of psychiatrists who are experts in this area is limited. Thus, their paths are likely to cross often, even if they do not work together daily or meet frequently. They may be emotionally like many in the military. It may be that those working in military forensics know each other more than is usually the case, and thus are more "like family."

At some military medical centers military psychiatrists may interact daily. If they know each other well, this may be ethically more problematic. They may unconsciously, if not consciously, decide not to challenge the opinions of other members in their "forensic group."

Case Study 3-3*:* Several military psychiatrists worked together at a major medical center. A soldier had committed a heinous crime. He also had (allegedly) been severely abused as a child. None of these psychiatrists believed that this soldier's childhood could have had a legally relevant effect on his intent to commit the crime. However, one of the military psychiatrists believed that the examinee might have committed the crime while in a state of dissociation. If this inference was correct and the judge believed that it was true, the examinee might have lacked the capacity legally to form the required specific intent. This was the view of another psychiatrist, a civilian who had testified for the defense.

If, however, the military psychiatrist thought that the examinee may have been in a dissociated state, he risked personal and emotional repercussions from his colleagues if he shared this belief with them. If he agreed with the civilian psychiatrist for the defense, he might lose his colleagues' respect. Those colleagues may perceive him speaking in support of the "Twinkie defense" used in the case, which indicated that the defendant's mental state was significantly altered by significantly elevated blood sugar levels. (The so-called "Twinkie defense" refers to a forensic argument that is so far-fetched and implausible that a criminal defendant must have lacked control because he or she had just eaten a "Twinkie," a sweet cupcake.) Since such claims lack the usual empirically based grounding, forensic psychiatrists often suspect psychiatrists offering such claims, as possibly doing this for less respectable motives, such as inappropriate bias or even for the money. The military psychiatrist knew that his colleagues had contempt for this defense. Thus, he feared that concluding that the examinee was not in a dissociative state may have been influenced (unconsciously) by his desire to avoid his colleagues' contempt. He did not know for certain, but like any military forensic psychiatrist concerned about his or her career, he feared that his concern about his colleagues' response could be unduly affecting him.

Discussion: Again, there is a parallel concern in research wherein there is often an absolute requirement that IRBs (groups deciding what research can be done) retain an outside member who is not part of the organization from which other members of the board are drawn. For example, if an IRB reviews all the protocols submitted by faculty from one university, it may need an IRB member who is not a full-time employee of the university. Otherwise, a conflict of interest would exist. If all IRB members were employees of the same university, they may feel obligated to comply with the university or principal investigator's need, whereas if not associated with the university, it would be easier to oppose these interests. These groups may be legally precluded from making a research decision unless this outside member is present.

For the same reason, military psychiatrists doing forensic work with others they know should consider and openly discuss how this context could affect them. By sharing and assessing these factors with each other, they may reduce their conscious and unconscious risks and effects. These discussions also may increase the degree to which they consciously consider these factors.

They may also go further by acting on these feelings if detected. They can presuppose that if they are aware of these feelings, then they are at risk. Psychiatrists'

capacity to identify their own feelings is an exceptional skill within this specialty. Psychiatrists are trained to assess the emotions they feel toward their patients and how this influences their actions. If it is assumed that they respond to their own emotional needs—and they are unaware of doing so—it may result in inadvertent harm to their patients.[10] If they detect such feelings, they can recuse themselves. It is essential that psychiatrists receive peer support if and when they choose to recuse themselves, yet they must allow enough time in advance so another psychiatrist can be notified to give an opinion to the court.

Some military psychiatrists doing forensic work may be at more risk of experiencing these effects than others. The risk is greater when forensic inferences are questionable. One example is the possibility previously discussed: when a defendant may have had a dissociative state during commission of a crime. This situation may be controversial for two reasons. First, there may be a question about whether the examinee actually experienced a dissociative state. A dissociative state may be more easily and successfully faked than other mental states, such as those involving psychoses. Second, even if the examinee was in a dissociative state, the question of whether it negated his or her capacity or intent may remain.

The next two subsections present two more examples in which forensic psychiatrists may feel these same kinds of emotional pressure and thus be at higher risk of being unduly influenced.

The Fear of Placing Too Much Weight on Examinees' Psychodynamics

Another type of case in which military psychiatrists may feel more reluctant to say what they believe is when their inferences regarding an examinee's criminal responsibility are based on their own speculations regarding examinees' psychodynamics. There are many concepts in psychiatry that may be sound but are difficult or impossible to verify, such as the concept of a repetition compulsion.[11–15] People surely enact repeated patterns, but the extent to which this behavior is compulsive and why it occurs are debatable.

If a military psychiatrist assesses an examinee for insanity or intent, he or she may feel more reluctant to divulge an inference based in significant part on a psychodynamic inference, such as that the patient acted because of a compulsion. He or she may feel more confident asserting that a defendant was psychotic at the time of his or her crime and lacked capacity or intent for this reason, especially when evidence indicates the defendant previously had psychotic thoughts and these thoughts have been present for many years.

Case Study 3-4*:* A soldier who was responsible for obtaining medical supplies for a military hospital failed to do so, and the hospital staff blamed him. He went to a small supply shed, and according to his testimony, tried to light this shed on fire so that he would die within this fire, but did not succeed. He was prosecuted for arson. In his past, he and his wife traveled from one concentration camp to another in Europe every year during his leave for more than a decade. He had lived in Europe as a young child, and Nazis had taken over a village in which he had lived with his parents. They were not Jewish, but he had a Jewish friend that was his age. One day the Nazis took his friend, her parents, and other villagers who were Jewish and encircled them in a fenced-in area. His parents urged him to slip through a hole in that fence to give bread to his friend and her family. One day he took bread, but found no one there. His friend, her family, and everyone who had been imprisoned within this fenced-in area were gone. According to his and his wife's testimony, they sought to find some mention of his friend while traveling to these camps. These trips were documented. Psychodynamically, it was plausible that these travels represented a repetition compulsion. If so, when he had been accused of failing in his job and others blamed him, he may have identified with his childhood friend and tried to end his life by burning himself, as he believed she had died. The jury thought it may have happened and acquitted him.

Discussion*:* The soldier's behavior on leave while traveling with his wife every year fits the description of a repetition compulsion. Psychodynamically, it makes sense that he later "compulsively" sought out information regarding his childhood friend and that when he was later blamed, he identified with her and attempted to end his life in the way that he claimed that she did. Military psychiatrists may reasonably differ on whether this psychodynamic speculation is valid and whether the effect of this compulsion could have altered the required criminal *mens rea* or specific intent necessary for him to be convicted of arson.

Would a military psychiatrist be less likely to use repetition compulsion for an examinee's defense when it is more speculative because it is being based on psychodynamic theory? This greater reluctance to testify to more speculative inferences may occur either consciously or unconsciously, and it also could be attributed to a military psychiatrist's career advancement concerns and desire to retain his or her colleagues' respect.

If military psychiatrists believe that they should give significant weight to psychodynamic factors, then they should not ignore these possible influential factors. When their inferences are more equivocal, they should especially strive to continue to say what they believe. Military psychiatrists identifying such reluctant feelings should share them with their colleagues and not fear their disapproval. In turn, their colleagues should support these psychiatrists in saying what they believe.

The Fear of Placing Too Much Weight on Unlikely Possibilities

Military psychiatrists conducting forensic exams to determine insanity may also be more reluctant to voice inferences regarding less probable possibilities. People perform criminal acts for reasons that are often unclear to psychiatrists as well as to themselves. Even improbable causes warrant consideration, particularly when no reasonably based motivation can be discerned.

When people perform a criminal act in which they become suddenly violent, it could be a paradoxical response "driven" by their use of a substance, such as alcohol.[16,17] In general, in the law the effects of alcohol and other substances are "no excuse." Yet, alcohol, like other medicines, may cause the first "episode" of a paradoxical reaction. Soldiers experiencing this first instance may have no knowledge (other than "common knowledge") that this paradoxical reaction can occur.

Likewise, soldiers may have unusual and unprecedented reactions that produce violent behavior from ingesting prescribed and illegal drugs. The best known example of a commonly prescribed medication that may produce violent behavior is zolpidem (Ambien, Sanofi-Aventis, Bridgewater, NJ). People that consume zolpidem may have blackouts or times during which they do not create memories and may also experience unanticipated responses to the drug. People may also have automatic behaviors during which they lack conscious awareness of what they are doing for other reasons. Examples include when one is awoken from a deep sleep or has a psychomotor seizure from epilepsy. Violent behavior may occur during these unconscious states for reasons that may depend somewhat on the source of these behaviors, but also, at this time, are often not understood.

Unusual causes of criminal behavior may help reduce a crime's severity by negating its intent and also acquit the offender. Yet military psychiatrists may be especially reluctant to raise these possibilities and voice inferences based on only plausible psychodynamic theory because their colleagues may deem it insufficiently objective. This reluctance may be particularly pronounced if they are situated in a program, such as a psychiatric forensic fellowship. In this context, their teachers may feel—as a result of raising these less plausible possibilities—that the psychiatric fellows are insufficiently objective; and in turn, this may affect their evaluations, recommendations, and futures, thus leaving them more fearful of responding in these ways. They may fear voicing these more remote possibilities even if and after they have imagined them. If voiced, military psychiatrists may fear lessening their career aspirations or losing their colleagues' respect.

Case Study 3-5*:* A soldier's psychiatrist had prescribed a benzodiazepine for sleep before zolpidem was available. He had taken it for some time, but suddenly became violent in his barracks and hit a fellow soldier in the middle of the night. All soldiers present, including the soldier who was hit, believed that these two soldiers were friends. The offending soldier had no history of violence or any illegal behavior. A military psychiatrist speculated that this may have been a paradoxical reaction to the benzodiazepine, and the soldier was acquitted.

Discussion*:* The possibility that this soldier's response resulted from a drug effect was more plausible than if an identifiable motivation for his violent behavior existed. Still, in this and less plausible contexts, military psychiatrists may be reluctant to raise such "far-fetched" possibilities, fearing that they would appear unduly gullible (and worse) be judged by their educators or colleagues to lack objectivity and have a "bleeding heart." These psychiatrists could again fear negative career effects or colleagues' disapproval. Accordingly, if psychiatrists believe that such speculations may have merit, but have these fears, they should voice both.

When a defendant may have had a paradoxical response to a substance, another legally pertinent question may also arise: Did the defendant know that he or she was vulnerable to having this bizarre effect from the substance? If this was the first time the bizarre effect occurred, he or she would lack this foreknowledge. The defendant might know that it could occur, but would not know that he or she could be affected in this way, and thus would not have this reason for not taking it.

Whether a defendant has foreknowledge about a paradoxical effect may have profound forensic significance. If a defendant lacked foreknowledge, he or she might be exonerated (as exemplified in this case). If psychiatrists ask if the same bizarre effect ever occurred, it may cause them moral distress because the answer may affect the legal outcome to this extent.

This situation applies to many forensic questions. As another example, an examinee may claim that he or she committed a crime in response to having had an auditory hallucination, but this did not occur in the above case. Psychiatrists know in advance which kinds of hallucinations are more likely to be real and which are more likely to be fabricated, and they know this better than the offenders. However, psychiatrists do not disclose their perceptions in advance. Using this same example for illustration, psychiatrists do not tell those they examine in advance which kinds of hallucinations are more likely to be real before asking them to describe their hallucinations.

Psychiatrists doing forensic evaluations may limit or eliminate some sources of moral distress (although not all) because they must withhold this information.[18] They want to eliminate or reduce these sources, even

though some are unavoidable. Examples include withholding information, such as the offender knowing he or she may have a paradoxical reaction to alcohol and which hallucinations are more likely to be real versus those than are not. In these contexts, as in the others discussed, forensic psychiatrists should seek to identify this moral distress and share these feelings with their colleagues.

DETERMINING MENTAL CAPACITIES OF SOLDIERS

Soldiers serving in Afghanistan now are especially vulnerable to blast injuries[19,20] that may harm their brains in ways that are not always obvious. The injuries may leave soldiers with essentially intact capacities for cognition, but disturbances in their feelings. These disturbances, which may stem from organic damage, may be exacerbated by stresses later in life or get better.

It may be that the brain damage caused by these blast effects sometimes differs from that caused by other trauma, such as car accidents. Thus, the standards that psychiatrists conventionally use to assess patients' mental capacities are not ideally suited for assessing soldiers who have sustained blast injury.[21] If military psychiatrists assess mental capacities using only the standard approaches, they may experience moral distress because the outcomes will be morally wrong.

Here are two examples. The first example involves soldiers so badly injured that they say they want to die. The second example involves soldiers who refuse a procedure, such as an amputation, which may also cause their death.

Soldiers Wanting to Die

In many contexts, the criteria for determining patients' competency to make medical decisions involve principally cognitive factors.[22] Patients must be able to understand their options and appreciate how they will affect them personally, be able to reason, and be able to indicate a choice. Soldiers may undergo other extensive injuries from blasts in addition to brain injuries, and they may want to—or at least *say* they want to—die. Military psychiatrists may need to assess whether soldiers have the mental capacity to make these life-or-death decisions.

In civilian contexts, as in military contexts, patients requesting to die after an acute trauma can pose this profound ethical question. A specific, paradigmatic example is when patients who have undergone acute traumatic quadriplegia ask to die.[23,24] These patients may have the capacity, as it is usually tested, to refuse all life-sustaining treatments. Psychiatrists usually test their patients by asking a series of questions to ensure that they understand their situation and by providing alternatives for them to make a decision that genuinely reflects what they want. Psychological testing is sometimes but not often required. Initially, these patients may want to refuse life-sustaining interventions for a reason that will later change. Patients may not be able to envision themselves valuing a life with injury. With time, however, they may change their mind and want to live.

This dilemma can occur for soldiers who have profound injuries, whether or not they sustained blast injuries that caused brain damage. If soldiers have had concomitant blast injuries affecting their emotions, military psychiatrists may have greater difficulty assessing mental capacity to refuse life-sustaining treatment, partly because of limited present knowledge regarding the injury effects. Military psychiatrists may believe that these soldiers' underlying feelings are so acutely altered by physical damage to "non-cognitive" parts of their brain that they, at this time, lack the capacity to choose to die. Brain damage to these "emotional" parts of their brain may be producing and "driving" their decision to die. Military psychiatrists making this determination may also believe that after some time these injuries and resulting soldier responses may "get better," and soldiers may want to live. Military psychiatrists may experience moral distress from the conflict between having only standard measures of mental capacity to apply and these beliefs. If they apply these standard measures, these soldiers may have the capacity to choose to die. If they apply some stricter standard that they may construct more on their own, these soldiers may not only live but also be glad they did.

Case Study 3-6: A soldier was injured badly from an explosive device. He lost all his limbs, and he was initially also cognitively impaired. When he became cognitively clearer, he stated that he wanted to die and requested to discontinue all medical interventions keeping him alive. Since at this time he understood his options, the military psychiatrist was consulted to determine his decision-making capacity to choose to die. The military psychiatrist believed that the soldier's decision may have resulted significantly from his underlying brain damage, and as he recovered he may change his mind. He believed that this soldier already had shown signs of recovery from brain damage, and thus it would continue.

The psychiatrist wanted to keep this soldier alive for a longer time, even if, based on standard approaches used to determine patients' mental capacity, he had the capacity to make the choice to die at this time. The psychiatrist felt moral distress and shared this with the staff. This soldier was told that he could not make this choice until he was transferred to a rehabilitation center.

Discussion: In this instance, the hospital staff was "successful" in delaying this soldier's decision to live or die until he had spent time at a rehabilitation center with others who had had similar injuries and decided that they wanted to live.

When severe injuries are involved, military psychiatrists (as other clinicians) may have different views to judge when these soldiers have full decision-making capacity. This judgment is especially difficult for military psychiatrists when these soldiers have had blast injuries. Detailed psychological testing has shown that although they may remain cognitively fully conscious of their options and be able to state them, other parts of their brains affecting emotions may be severely damaged. These emotions may influence and even determine whether they want to die, although this damage may be difficult to detect without formal, extensive psychological testing.

If the patients are deemed initially to lack adequate decision-making capacity, they may acquire it later. Then they would decide to die by refusing life-sustaining measures. In these instances, it would be ethically optimal if psychiatrists use a "sliding scale" for determining capacity because it is a stricter standard. In many contexts psychiatrists use a uniform standard for determining patients' capacity to make a decision such as to refuse life-maintaining treatment. This standard may seek to understand this decision and its alternatives. With a sliding scale the psychiatrist alters this standard somewhat from patient to patient, depending on the individual's situation and needs. Using this sliding scale, the psychiatrist may use a strict standard or one that requires a high degree of understanding for a 21-year-old person who has just become paralyzed in a car accident, is on an artificial ventilator, and requests that the ventilator be turned off so that he or she can then die. Why? There is a great difference in possible outcomes. This patient may—like the late Christopher Reeve (the actor who played Superman in the movies)—find that life, even when paralyzed, is most meaningful and worth living. He or she might then live and enjoy several more decades of a meaningful life.

However, a psychiatrist may apply a much less demanding standard for determining a patient's mental capacity if he or she has a lethal, untreatable cancer, and is refusing a fourth trial of an experimental treatment after three failed treatments. Here, the different possible outcomes are much closer to each other. With or without the experimental treatment, this patient, most likely, soon will die. Thus, it may make sense to require this patient to have less of a complete understanding so he or she can still have what he or she wants.[25,26] Yet, for this to occur, military psychiatrists need explicit guidance that this is acceptable or that using such a sliding scale is clinically and morally preferable.[27]

Soldiers Not Wanting an Amputation

The moral problem presented previously may occur in many guises. Soldiers may experience great damage and resulting infection to a limb, and then an amputation is needed to save their lives. But they may refuse this procedure after they also have had a blast injury causing brain damage.

Case Study 3-7: A soldier suffered a blast injury and sustained a concussion and extensive injury to a leg. He was shipped back to the United States for medical treatment, but his leg infection worsened. All the medical staff believed that a leg amputation was necessary, but this soldier refused. There was division among the staff as to whether this patient had the capacity to make this decision. Some felt that since he understood his options, he had this capacity. Yet, extensive psychological testing showed many impaired mental capacities.

Many staff members believed that proceedings should be initiated to declare the soldier incompetent so a substitute or surrogate decision maker could be appointed. Fortunately, before the proceedings became necessary, the soldier changed his mind. Surgeons performed the amputation, and he survived.

Discussion: This case raises the possibility that present approaches to assessing patients' mental capacities may not suffice when soldiers have experienced blast injuries because the harm caused by these explosions may be essentially unprecedented and unique. These soldiers may retain their capacity to understand and accurately articulate their options, but substantial brain damage may exist in the emotional parts that "drive" their cognition. Their emotions may lead them to an outcome that is neither their "genuine" desire, nor what they will later want.

Military psychiatrists experience moral distress over this dilemma. They may feel that they must apply approaches that reflect an understanding of the adverse effects of blast injury on the brain for determining the patient's mental capacity. However, these approaches may have been selected before for patients with different kinds of cognitive impairment. The approaches psychiatrists use to determine the capacity to make choices such as whether to have a life-saving amputation, after a soldier has had a blast injury, would be to use the same standard as psychiatrists have used previously as those checking for cognitive understanding.

The brain injuries caused by blast injuries may be unique, such that the approaches previously used for patients with other conditions may not suffice. These other approaches give greatest priority to patients retaining the capacity for clear thinking. Blast injuries may, however, leave patients' capacity for clear thinking intact but destroy other parts of the brain. This damage may be less detectable on standard clinical interviews or exams or not detectable without extensive

psychological testing. Thus, these patients' capacity to assess what is most important and accurately gauge what they want may be grossly impaired, even though they may retain the capacity for lucid thinking. A new standard for judging these patients' capacity may be ideally needed since this would be best for them, although this need may not be sufficiently recognized or then, accordingly, developed.

Other causes of military psychiatrists' moral distress may also drive new kinds of thinking and some may involve new kinds of law. An example is a case in which a psychiatrist examined a soldier who committed a crime for which he could have received a death penalty. However, he agreed to life imprisonment. A military psychiatrist determined that the soldier lacked the required mental capacity to commit the criminal act that could have resulted in his death. The prosecution said, however, that unless the soldier agreed to "drop" this psychiatric defense, based on his lacking the prerequisite mental capacity, it would use this same military psychiatrist's findings to negate the prior agreement to "only" accepting life imprisonment. The prosecution would say that he lacked sufficient capacity at the time to agree to life imprisonment, and then seek the death penalty. At the advice of his defense attorney, he withdrew this psychiatric testimony. It might be preferable if the law is altered so that this outcome cannot recur. The present law may allow an unjust outcome.

Another example is a military psychiatrist who determined that a soldier had an emotional impairment that would have greatly reduced the severity of his crime from a more serious crime, requiring pre-meditation and intent, to one less severe that did not involve this same degree of intentionality and preplanning. This psychiatrist was barred for legal reasons from presenting his view to the court. This outcome, again, may be unjust but could be changed.

It may be that military psychiatrists' moral distress may be a clue to them to consider such changes that should be made for ethical reasons. Their moral distress also may suggest the need to develop new criteria for determining soldiers' capacity after a blast injury and for new legal procedures such as the two described previously.

Soldiers deserve all benefits that psychiatry and the law can allow, even if the approaches depart from civilian psychiatric practices in analogous contexts. Ethically, these departures may be particularly justifiable on the basis of the moral principle of compensatory justice, which involves the effort to help compensate soldiers for their willingness to risk their lives and limbs for their country.

CONCLUSION

In many situations, military psychiatrists feel moral distress when they conduct forensic evaluations. They may feel less distress if they fully understand the value conflicts underlying it.[28] In some contexts, this distress may be irresolvable and military psychiatrists should share their dilemma and its angst with their colleagues.

This chapter presents three contexts in which military forensic psychiatrists may face ethical conflicts and feel moral distress. The first involves military psychiatrists examining soldiers who they fear may be overly compliant from their habit of obeying orders. In this case, military psychiatrists might give increased warnings. The second involves military psychiatrists feeling conflict in part posed by their own needs. In this case, they may "air" these conflicts, and those working with them may seek to reduce these conflicts. The third involves clinical situations in which present approaches for determining soldiers' mental capacity may be suboptimal. The prime example used here is assessing soldiers who have suffered blast injuries. These injuries may differ qualitatively from other brain injuries, such as those resulting from car accidents, and thus the standards used to determine mental capacities may need to be altered.[29] In this case, military psychiatrists may do this now by using a "sliding scale," but, for them to feel able to do so, military medical authorities may have to give explicit support to this innovative practice.

Legal practices that now allow or even further suboptimal outcomes may need to be changed to best meet soldiers' needs in some forensic cases. Military psychiatrists' moral distress may provide clues as to when this should occur. A chief rationale for military psychiatrists and others considering not only these legal changes but also all these suggestions listed previously is the ethical principle of compensatory justice. These suggestions, whether or not valid, still represent and model how military psychiatrists and others may optimally respond when they feel moral distress. They might try to identify the sources of this distress and determine whether ethical conflicts and better resolutions could be pursued. Military psychiatrists' capacity to recognize their own feelings and this distress is their "bread and butter." Consequently, they are particularly well trained and equipped to pursue these kinds of innovations.[30]

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